City of Long Beach
Health/Dental Insurance Selection Form

Current Plans	Action	Health	In-Hospital Indemnity	Long Term Care
Health: Dental: In-Hospital Indemnity:	Indicate all actions that apply: ☐ New Enrollment ☐ Open Enrollment ☐ COBRA Enrollment ☐ Plan Change ☐ Name/Address Change ☐ Add Dependent ☐ Delete Dependent	Enroll or change to: POS ☐ POS 100 ☐ POS 90 PPO ☐ Great West PPO ☐ PPO Thrift Plan HMO ☐ PacifiCare **Dental** Enroll or change to: ☐ Delta ☐ PacifiCare	Enroll or change to: ☐ (01) Employee Only ☐ (03) Employee & Spouse ☐ (04) Employee & Domestic Partner ☐ (05) Employee & Child(ren) ☐ (07) Employee & Family ☐ Decline/Terminate Coverage	Are you interested in signing up for Long Term Care? ☐ Yes ☐ No Note: New employees are guaranteed a policy for themselves within 30 days of hire. Employees and spouses must complete a medical questionnaire (included in application package) as part of the application process.

Form Effective Date: | Payroll Deduction: | 040 Amount $ | 044 Amount $

Employee Name | Birth date

Home Address | Sex

Marital Status

Home Phone | Social Security No.

Dept/Bur/Div | Hire Date | Marriage/Divorce Date:

Do you or any dependents have other health insurance?

☐ Yes ☐ No

Name of Insurer

Policy No.

Employer Name (if applicable)

If any dependents live at a different address, please indicate:

Name	Complete Address
Name	Complete Address
Name	Complete Address

LIST SELF AND DEPENDENTS (if applicable)

	Relationship	Name	Add/Delete	SS No.	Birth date	Sex	POS/HMO Only: PCP Name	POS/HMO Only: Group Name or No.	POS/HMO Only: Current Doctor	PacifiCare Dental Code
									Yes No	
									Yes No	
									Yes No	
									Yes No	
									Yes No	
									Yes No	

Beneficiary Information:
If you are changing coverage due to a change in family status and need to change your beneficiary information, please check the appropriate box: ☐ Life Insurance ☐ PERS ☐ Deferred Compensation

Enrollment Agreement and Payroll Deduction Authorization

I acknowledge that the above information represents my enrollment choice(s). I understand that by signing this form I am electing to reduce my compensation in exchange for pre-tax health care coverage and I authorize payroll deductions for any required contribution. I understand my coverage elections cannot be changed until a future benefits enrollment period. I represent that to the best of my knowledge and belief, all statements and answers made on this form are true, complete and correct. If applicable, I hereby authorize any insurance company, hospital, physician or any other health care provider to release all information to all those who may have a bearing on benefits payable under this plan. Adjustments may be made to increase or decrease the amounts specified for deductions identified above by the City's Coding System, provided that the method, manner and amount of each such adjustment is in full compliance with the applicable laws or administrative rules and regulations of the City.

PacifiCare HMO Medical Coverage and PacifiCare Dental Coverage Agreement

If I elect medical coverage through PacifiCare HMO, I authorize anyone providing service to me or my eligible dependent(s) to release to PacifiCare HMO any information or medical records relating to those services. I agree that except for life-threatening emergencies, all medical services must be performed, prescribed, or authorized by my designated HMO provider. Enrollment in certain health plans constitutes an agreement to have a dispute decided by neutral arbitration and a waiver of any jury or court trial. Refer to the enrollment information to determine if and what types of disputes apply to the plan in which you have chosen to enroll. If this provision applies, your signature below means you agree to such arbitration for yourself and your enrolled dependents.

I understand and agree to the terms and conditions described above.

_____ _____
Employee Signature Date